We are in a strange lull, a lull in which newspaper stories inform us, and I quote the Washington Times of June 23:

Some [GOP leaders] said even a Senate-House conference to iron out differences with Democrats over gun-control provisions in a juvenile justice bill is now in doubt.

I am told today that Mr. ARMEY said at the very earliest, conferees would not be appointed until after the July 4 recess.

First and foremost, conferees ought to be appointed. We should not simply stop the process because some people, certainly a minority of the Members of Congress, and certainly a minority in terms of the views of the American people, do not want it to happen. The Senate debated the issue. We should have the ability to go to conference. I call on the House leadership to appoint conferees quickly and with alacrity so we might debate the provisions here, not only the gun show loophole but many of the provisions that people on both sides of the aisle support that would make it easier to punish violent juveniles as adults and that would provide some of the prevention services that young people need. Because juvenile justice and closing the gun show loophole is a priority to many Americans; to a large majority of Americans, in my opinion.

Two weeks ago, for instance, a month after we passed the juvenile justice bill, we passed the Y2K liability bill. Lo and behold, Senate conferees were immediately appointed, and I understand we are now close to an agreement. In fact, I believe an agreement is due this afternoon. I think that is great. But Y2K is a far more complicated bill than juvenile justice. It is treading on fresh new ground.

The millennium, by definition, occurs every thousand years but we finished this one right up. The juvenile justice bill, however, is in stasis. There are things that can be done to get it moving. The most obvious is for the House leadership once again to appoint conferees so we can debate the gun show loophole. The real problem I fear is that those in the Republican House leadership do not want to continue to debate this issue. They know their allies in the NRA and the American people, including most gun owners, are divided because most Americans, including most gun owners, sincerely believe providing a background check at a gun show does not infringe their rights just as we now provide that a background check must be done when you buy a gun at a gun shop. But they do not want to do that.

So there are other things we should consider to get things moving. Perhaps we can add these provisions to a bill that has to be conferenced. Perhaps we can add this to other types of proposals which the other body sees a need to have go forward. But I am issuing this challenge, particularly to the House leadership but to all of my colleagues: We should pledge to send a juvenile justice bill, one way or another, to the President's desk, a bill which includes the Senate gun show provision, by the first day of school, the Tuesday after Labor Day. That is 2 months to pass a bill that we already passed. If we do not, and there is, God forbid, another school shooting, we will sorely regret our inaction.

I yield the remainder of my time.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. REED. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REED. I thank the Chair.

PATIENTS' BILL OF RIGHTS

Mr. REED. Mr. President, I will speak for a few moments about a topic that has consumed many of us for many days this week and preceding weeks, and that is the Patients' Bill of Rights.

A particular concern to me has been the status of children in the various versions of the Patients' Bill of Rights. I argue very strenuously and very emphatically that the Democratic proposal recognizes the key differences between children and adults when it comes to health care, and there is a significant difference. For a few moments, I will try to sketch out some of these differences.

First of all, if one looks at the adult population in terms of types of illnesses, they are characterized as chronic diseases with relatively simple symptoms, simple manifestations with known consequences. They are quantifiable over a short period of time. Prostate cancer, breast cancer, heart attack are familiar diseases to all of us.

The other aspect of adults is that there is a large volume of adults who have these types of diseases. As a result, there is more than a sufficient supply not only of physicians but of specialists, those who are particularly skilled and particularly knowledgeable about the most efficacious treatments one can use for these types of conditions.

In contrast, children present another type of population to the health professionals. The good news is that most children are healthy. But if a child is sick, that child usually does not have one of these chronic diseases that is well-researched and well-treated and staffed by numerous specialists, but something more complicated. In fact, as the professionals say, these diseases are usually complex and with multiple co-morbidities. For the layperson, that means different problems interrelated causing a much more complicated case for the physician.

There is another aspect of this dichotomy between adult health and children's health. There are so many healthy children —the good news. The bad news is in terms of managing this population, there is a very small volume of very sick children. This makes it very difficult for physicians to maintain their clinical competency, particularly for general practitioners. They will see many adults who have similar symptoms and they know very well how to treat them. By contrast, they very rarely see chronically ill children, so treating them effectively becomes especially difficult for a general practitioner.

Another difficulty is the sense these general practitioners or even adult specialists can treat this population of patients. There is a further complicating factor, that is, to manage cases you need volume, you need data, you need to understand what the best treatments are, and you can only do that in a rational way by studying lots and lots of cases and, frankly, because of the nature of children's health, they do not have the same type of volume in children's diseases as they do in adult illnesses.

One other complicating factor is that many times children's true health conditions manifest themselves long after they have actually contracted the condition. It is not the short duration, it is not the heart attack that one can rush the person into the emergency room, do the surgery, apply the drugs, and get that adult on the road to recovery. It is much different when it comes to a child.

Managed care organizations and the way they deliver care can compound these inherent differences between the adult population and the children's population.

First, let me give credit where credit is due. When a managed care plan does it right, they do preventive care very well. They can anticipate, through the management of the child's case, immunizations and well-baby visits, et cetera. But there are certain inherent characteristics of the managed care system of health care delivery that makes it—appropriate for adults but less appropriate for children. That is why we have to focus a part of our efforts on making sure that children are truly recognized in the legislation we are discussing.

First of all, because there are a relatively small number of very sick children, there is not the adequate number of patients for the HMO to maintain a number of pediatric specialists in their provider network. The other fact is that HMOs tend to fragment the market. They go after parts of the market

and leave other parts out, but they do not tend to accumulate large groups of children so that a pediatric specialist in a particular area can be fully employed.

Another aspect of the managed care delivery system is that they typically look for an affiliation with what they call centers of excellence, hospitals that are well-known for their practice in a certain field of medicine. In most cases, what they consider to be the center of excellence is a center that provides the best adult medicine because after all, they are marketing their products to adults, not to children. They are marketing their products to human resource managers who have to buy for a company, or they are marketing directly to people who make decisions about health care who are by definition adults. When they are out looking for centers of excellence, they are looking for those hospitals that have the best urology departments, have the best records with prostate cancer and breast cancer and heart attack. That is another built-in aspect of the HMO dilemma which complicates the care to children.

There is something else. There is an economic incentive for these HMOs to refer children to adult specialists and not to pediatric specialists. There is a great difference between a cardiologist and a pediatric cardiologist because of the differences in caring for a child versus caring for an adult. The incentives are sometimes very compelling.

For example, if you have a staff model HMO—that is where the doctor actually works for the HMO—you have a cardiologist simply because that is expected, and if you look at the numbers, you are likely to have a lot of adult cardiology patients and very few children. To add a pediatric cardiologist increases the fixed costs. Why do that when you can simply make a referral to the adult cardiologist that is already in the plan's network?

When you look at the nonstaff model, one where they will contract with individual physicians, typically what they will do is look at volume discounts. A physician will say: Sure, I will sign up for so much per visit, but you have to assure me that I will get a lot of visits. That is another incentive to drive children not to pediatric specialists but to adult specialists.

As a result, these incentives tend to diminish the quality of health care that HMOs give to children, particularly very sick children. It is not because they have some type of grudge against kids. It is simply, if you look at the market dynamics, if you look at the volume they are trying to manage, it all argues against the type of care that sick children must be assured. In other words, there is a failure in the market to recognize the needs of children.

That is why we have to step in. That is why we have to require HMOs to make sure that there is access to pediatric specialists, to make sure HMOs are tracking the health progress of children, to make sure they are measuring their outcomes in terms of children and not just adults. If we do not, the system will always be driven to the needs of the adults who managed care plans are trying to recruit as patients. Another way to say this very simply is that HMOs operate on economies of scale. That is how they make the money. And children with particularly complicated pediatric health care cases do not conform to those types of economies of scale.

I mentioned before there are other particular issues about the health status of children that make them distinct from adults, and one of them is the fact that children are still developing. They are constantly changing their functional levels —mobility, toddlers start walking, and then they start running, speech, puberty—all issues which are seldom associated with adult health.

As a result, unless you consider development as a first order of priority, you are going to overlook a lot of the emphasis that should be placed on children's health care. I suggest that most HMOs do not factor in the sensitivities to development that are so necessary.

Also, when you get into a situation like this, when the development of a child is at stake, the challenge is early intervention. It is not simply catching the disease someplace along its course and providing some type of treatment. It is early intervention.

There are numerous examples. One that I recently read about is a condition in infants called strabismus, which is muscle weakness of the eye. If it is not corrected soon after birth when the neurological connections between the eye and the cortex of the brain are being formed—again, this is not a situation that an adult would ever encounter—if you do not catch it early, you are going to have significant and irreversible loss of sight.

That is a special concern for kids, a very serious developmental concern for children diagnosed with the disease. That is why we need to make sure that development is built into HMOs consideration of the type of treatment and services they provide children. The economics of HMOs means they will not do it themselves. Therefore, we must make it our job. I think that is what is part and parcel of a good part of the Democratic initiative.

Let me suggest something else on the issue of development. My colleague from California, Senator FEINSTEIN, and so many others, have talked about medical necessity. This whole definition of medical necessity tends really to prejudice kids from getting a fair shake in HMOs, for many reasons.

First of all, most medical necessity determinations are documented by data. How efficacious is the treatment? How often do we use it? And it goes right back to one of the inherent issues: The very lack of the volume of seriously ill children to generate the kind of data, treatments and outcomes.

There is nothing in the law that I can see today at the Federal level that even requires HMOs to start thinking about outcomes, to start thinking about effectiveness in terms of kids.

The other thing that we should be concerned about is that a lot of medical necessity is cost based—using the cheapest option. Once again, when you have a very small volume of very sick kids, the appropriate form of treatment may be extremely costly.

Another factor concerning medical necessity is that usually it is tied to the notion that a health plan will not pay for innovative treatment. It will not pay for experimental treatment.

Once again, many of the treatment modalities used for children, simply because they are not routine, can be called innovative or experimental. That is another example of how children are prejudiced by the system. It is something that we have to correct.

Finally, very seldom will you find in the definition of medical necessity this concept of developmental impacts, beyond simply returning to normal function. As a result, it is easy for HMOs to say a treatment or procedure is not medically necessary when children present themselves or their parents present them for care. It is not threatening their lives today, or even their ability to function today. However, they probably know that months from now, a year from now, 2 years from now, their development will be severely impaired. But that is not part of medical necessity. So that is another example of why we have to step up to the plate, particularly when it comes to children.

We have learned so much about the development of young children, particularly from ages 0 to 3, including the way the brain develops.

Once again, this is an issue that has very little correlation with adult experience. Children are developing.

Just a few examples.

At the Baylor College of Medicine there was a survey of abused and neglected children. They focused on 20 children who they described, in technical jargon, as living in ''globally understimulating environments.'' In other words, these children were rarely touched; they had no real opportunity to play; they had no opportunity to explore and experiment. They found that the brains of these young children were 20 to 30 percent smaller than those of children who had the opportunity to be stimulated. Indeed, literally parts of their brains had wasted away. Again, this is an issue that would never confront a practitioner looking at an adult.

Another example relating to development is in the area of childhood trauma. We have been able to show, through scientific examination, that children who have witnessed violence have physically continued to register that violence, they remain in a high-alert state, and this leads to emotional, behavioral and learning problems.

Again, these are conditions that you would never find in an adult, with some exceptions of course. But they are part and parcel of the developmental process of children. If we do not understand that, we do not recognize it. If we do not provide particular protections for children, it will not be done by the HMOs. It costs too much. They do not have the data. It is just something that they do not think about a lot.

I see my colleague from Oregon is here. Let me make one other point, if I could.

Mr. WYDEN. I just want to, at a convenient time, ask my good friend from Rhode Island to yield for a question or two because I think the Senator has made an excellent presentation on the need to advocate for kids. All the latest research with respect to these children is really dropped-dead material. Unless you get there early, as the Senator from Rhode Island is suggesting, you end up, with a lot of these poor kids, playing catchup ball for the next 10 years.

So when it is convenient, I would like to engage the distinguished Senator from Rhode Island in a few questions about some of the other areas where he has contributed on this bill that, frankly, I think ought to help bring the parties together and help us fashion a bipartisan proposal.

I just want the Senator from Rhode Island to know how much I appreciate him standing up for those kids who do not have political action committees and do not have clout and cannot speak for themselves. At an opportune time in the Senator's address, I would like to be able to ask the Senator to yield just to address a few other questions about some of the areas on which he has focused.

Mr. REED. I thank the Senator from Oregon.

I want to make one final point about children, and then I would very much like to yield to the Senator. And I compliment him, too, on his efforts because we are working together on many of these issues, including children's health.

One final point: Children's health is, I would argue, more dependent on environmental conditions than adults. Of course, there are certain situations in the workplace where adults are exposed to chemicals, and we try to deal with that in terms of regulations and standards. However, it is also important to recognize that children are particularly prone to environmental and sociological conditions.

For instance, lead poisoning—it is an epidemic in so many cities. In my city of Providence it is an epidemic. But it is not just Rhode Island, it is across the country.

For too long, we used lead paint in houses, and now we do not have enough HUD money to clean up homes that have lead-based paints. That is why so many children have lead paint poisoning.

We have to recognize, for kids, is they these are important health problems. We have to be developing mechanisms so managed care organizations recognize these issues as health problems and that the Government recognizes them as health problems, and that they work together with linkages.

My final point is, unless we pass the kind of language that we have in the Democratic alternative, we are not going to give the special needs of children the attention it needs and deserves. When we start collecting the data, when we start having the HMOs publish what they do for kids—what is their success rate with kids? How many kids with complicated conditions do they have enrolled in their program? When we start doing that, they are going to have an incentive to start talking to the schools and the local authorities about their patients because now they have a real visible, accountable incentive to do it.

Just one final point: Again, Bruce Clarke, Gen. Bruce Clarke, one of the great combat leaders of World War II, said—and I remember this from my days at West Point—''A unit does well what its commander checks. If the commander doesn't check, you are not going to find that unit paying attention.''

We have not been checking on kids in HMOs in this country. I do not think they are doing particularly well as a result. When we start checking on kids specifically, as the Democratic alternative does, then we will start doing much better, I think we will start doing well.

I yield to the Senator from Oregon.

Mr. WYDEN. I thank my colleague for yielding. He has made an excellent presentation with respect to the need for strong advocates for these kids.

I will turn briefly to another area where the Senator from Rhode Island has, in my view, done yeoman work, and an area, frankly, that I think has sort of gotten lost a little bit in this discussion. That is the proposal the Senator from Rhode Island has made with respect to having ombudsmen or advocates for consumers around the country. It ought to be one of the areas that both political parties could gravitate to, because I believe that what the Senator from Rhode Island has done—of course, we have gotten great input from Families USA and Ron Pollack and some of the folks who have done so much for consumers over the years—is essentially talk about a true revolution in the area of consumer protection.

What happened—I have seen this so often since my days as director of the Gray Panthers; I was head of the Gray Panthers at home for about 7 years before I was elected to the House—what we saw was that the consumer would have a problem and, without any advocates or the ability to get it handled early on, a problem that started off relatively modest and minor would just fester and get worse and eventually blossom into a huge controversy which ended up in litigation.

As the distinguished Senator from Rhode Island knows, one of the most controversial aspects of this whole debate about managed care is litigation. It seems to me that if the Senate were to adopt the proposal of the Senator from Rhode Island or some version of it, this would shift the focus of consumer protection away from litigation, away from problems after they have unnecessarily developed into something serious. Instead, we would resolve a lot of the problems early on and we wouldn't need this focus on litigation.

Certainly, we ought to have legal remedies for the really outrageous examples of consumer rip-offs and the like. But I think what the Senator from Rhode Island has done, and it is such a valuable service in this debate and a real revolution in consumer protection, is said: Let's get at it early on when the consumer and the families can find somewhere to turn. We will prevent problems then. It can be done relatively inexpensively.

I would like the Senator from Rhode Island to elaborate a little bit on this and make sure that over the next few minutes the Senator from Rhode Island can lay out his proposal, on which I am honored to join with him. I think this has the potential of, frankly, being one of the areas where the parties, once they focus on it, can say: This is good public policy that will reduce the need for litigation and, as Ron Pollack and Families USA have said so eloquently, help a lot of consumers when they need it most. Perhaps the distinguished Senator from Rhode Island could take us through it.

Mr. REED. I thank the Senator from Oregon for his very kind words. Let me also thank him for his help and support in working so closely with me and Families USA and others to ensure that this proposal will work for all consumers and for the insurance industry as well.

Part of our attempt is to find answers before, as the Senator from Oregon has said, they wind up in court. My experience—I think your experience, too—is that people want their health care to be addressed. They don't want a lawsuit. They want to get their children cared for. They want their

own health care. This is not an attempt to figure out some way to get involved in a messy multiyear litigation process. Yet if there are no mechanisms, such as an ombudsman and an internal/external review process, if we don't have these mechanisms, that is where we inevitably will find ourselves.

Let me quickly accept the Senator's invitation to lay out some of the details.

First, it would be a State-based program, not a national program in the sense of some collective wisdom here in Washington, but each State could design their own ombudsman program. We would provide financial support. There would be some general guidelines for the states to follow. Basically, this ombudsman operation or consumer assistance operation would inform people about their plan options that are available and to answer other questions about a person's health plan.

Frankly, one of the great dilemmas most of our constituents have is, they don't know whom to ask about health plans, what health plans are available. This would be a source, a clearinghouse, if you will, for that type of information.

Then the ombudsman or the consumer assistance center would operate a 1–800 telephone hotline to respond to consumer questions and requests for information—again, such a necessary ingredient, for several reasons: First, the general befuddlement one experiences when you try to read a health plan contract. Two, I sense there is deep skepticism about the kind of response you expect to receive from your own insurance company about your rights and your benefits, if you get a response at all. Too many times I have heard constituents say they have just found themselves entangled in a voice mail hell, if you will. As you push one number and find one recording, you push another number and find another recording. The ombudsman program with the 1–800 number would serve as a place where you could get information and get it quickly.

Then this objective ombudsman, or woman, as the case may be, would provide assistance to people who think they have a grievance. They would have an opportunity for a patient to go in and say: My plan said I could not have this procedure for my child. My doctor says my child needs it. Can you help me? Frankly, not only will the ombudsman help the individual consumer, but they will look at the plan, and they will conclude that under the terms and conditions of the contract, that is or is not covered.

It won't be the insurance company protecting their own interest, it will be an objective agency that will be able to step in and advocate for consumer rights when they need to vindicate their rights and explain to them the limitations of the policy, when that is the case.

That is the general outline.

I yield the floor.

Mr. WYDEN. I appreciate the distinguished Senator yielding. I have felt that he has really gone to great lengths to try to ensure that this could be supported by every Member of the Senate.

Frankly, I feel about his proposal much like I do about the gag clause discussion. I think he and I have talked about this. I am probably a lot of things, but one of the last things I guess I would qualify as is an HMO basher. We have a lot of good managed care in my part of the United States. My hometown of Portland has the highest concentration of folks in HMOs in the United States. About 60 percent of the older people are part of a managed care program.

The distinguished Presiding Officer, Senator SMITH, and I have worked together on a lot of these issues. Frankly, one of our big concerns is, we do offer a lot of good managed care. We end up getting the short end of the stick in terms of reimbursement. I think what the Senator is talking about with an ombudsman, much like gag clauses where people, of course, ought to be entitled to all of the information about their options, the ombudsman concept is much the same kind of approach to good government.

The Senator from Rhode Island has written this now so as to ensure it cannot result in litigation, that this specifically is designed to help consumers at the front end and bars litigation. I don't think the majority of the Senate is aware of that. The Senator from Rhode Island has indicated to this Senator and the Senator from Maine, Ms. COLLINS, who has been very interested in this issue over the years, who has done good work, that he wants to make sure we don't duplicate existing services.

I am happy to yield to the Senator.

Mr. REED. Reclaiming my time, it is quite specific in the legislation. Again, the Senator is one of the contributors to this legislation, along with Senator WELLSTONE, and I thank him.

The ombudsman, or the consumer assistance center, could not participate in litigation. Their scope of participation is informal and could include contacting the insurance company, explaining rights, advocating for the patient as an ombudsman, not as a lawyer, not as a litigator.

Let me add one other point and then, again, yield to my colleague from Oregon. Interestingly enough, again I think he has identified an issue that we all can rally around. One of the great talents the Senator from Oregon brings to the Senate is an ability to be a bridge in so many different ways, i.e., the Education Flexibility Act—to find a mechanism that we all can agree upon.

This is another one of these areas. Interestingly enough, a few weeks ago we passed with little controversy and with much enthusiasm the defense authorization bill that included an authorization for an ombudsman program to address the problems and complaints associated with military HMOs—the TRACER system—looking at the same problem that all of the Senator's constituents from Oregon face, and all of my constituents face, but in the context of military families and complaints, and legitimate complaints of military families. They cannot get the care they need. They cannot get the answers. They get the runaround. They do not get the support.

In response to that, this body voted enthusiastically to authorize an ombudsman for the TRACER system. Frankly, both the Senator from Oregon and I are saying if it works well, or we think it is going to work well for our military families who are enrolled in an HMO that has a great deal of responsibility for them, why not give it a chance in the context of the private insurance HMO industry in the United States?

I think that underscores what the Senator from Oregon has said. This is not controversial. This is helpful. This is practical. This is not about litigation, it is about making sure that people get answers, that people get results, and that people get the care. That is what I think we are all here to do.

Again, I will yield.

Mr. WYDEN. I appreciate the chance to continue this for a moment because the Senator from Rhode Island is essentially being logical. Heaven forbid that actually takes over some of the debate we have. There is nothing partisan about making sure that consumers have all the facts about their health care. That is the effort with respect to barring gag clauses. And there is nothing partisan about this ombudsman approach.

I am very hopeful, frankly, that as the Senate learns more about this kind of concept pioneered by the Senator from Rhode Island, Families USA, and others, that we will see some of the good health care plans in this country saying we are going to support this because it makes sense to solve problems early on.

Frankly, if we can win support for the REED proposal early on—I am honored to join in on it—I think this will go a long way to eventually resolving the controversy about litigation because I think we will see good advocacy programs early on, and we can confine then the need for litigation to really only the outrageous, outlandish cases where I think every Member of the Senate would say, goodness, this is an area where you really ought to have a legal remedy. But we would have skewed the whole system toward prevention and early intervention, or answering the questions that the Senator

from Rhode Island has properly identified.

I will tell you that in my hometown, where we do have a lot of good managed care, folks want to see this kind of proposal. They want to see what is laid out in the legislation that our colleagues on this side of the aisle are offering, and they want to see us reach a bipartisan agreement.

The Presiding Officer of the Senate and I have had the most competitive elections in the history of the West. We have teamed up together on a whole host of issues in the Senate.

It would seem to me that around the ombudsman program and around barring gag clauses, this is another area where essentially partisan politics ought to stop outside the Chamber. We ought to work together to enact a good ombudsman program to say that this is the best anecdote to frivolous litigation, frankly, that we could possibly find.

I thank the Senator from Rhode Island, with whom I have enjoyed working for well over a decade on senior and consumer issues, and for the chance to work with him on it.

Perhaps by way of wrapping up my question to the Senator from Rhode Island, could he fill us in on progress with other colleagues? I know that Senator COLLINS has been very interested in this issue. She has done good work in her home State of Maine. Perhaps the Senator from Rhode Island could just wrap up by telling us where his proposal stands. I want to assure him and Senator KENNEDY, who has been leading this fight—and I am anxious to work with him. In fact, when I first came to the Senate, just a few weeks after arriving I had a chance to work with the distinguished Senator from Massachusetts on the effort to bar gag clauses. I only wish we had gotten that in place back then several years ago. It is long overdue that we get that protection for consumers as well as the Reed proposal.

Perhaps the Senator from Rhode Island could tell us where the ombudsman proposal stands at this time.

Mr. REED. Very quickly, we have been working, as the Senator knows, closely on the Reed-Wyden-Wellstone proposal, which was formally introduced as separate legislation. It is incorporated in the Democrat Patients' Bill of Rights. I know Senator COLLINS of Maine is very interested in this issue. I think she is also convinced that this is important and significant.

Let me also say that the Senator from Oregon made reference to his experience as a senior advocate. There are, in fact, senior ombudsman programs throughout the United States which we support with the Older Americans Act. These programs have been very effective and are doing precisely what we want to do in the context of managed care.

Again, we just adopted an ombudsman program for military personnel in the TRICARE system. It was noncontroversial. In fact, we have a great deal of expectation and hope that this will be helpful to our military families. We are working together across the aisle. I hope that we can also incorporate this provision in whatever Patients' Bill of Rights legislation that emerges. It is not designed to be a tool of litigation; it is designed to be a tool of conciliation.

On those grounds, I am optimistic and hopeful.

But, once again, let me finally conclude by thanking the Senator from Oregon not only for our colloquy this afternoon but also for his support, not only on this issue but so many others.

Mr. WYDEN. I will be very brief as well.

I think the distinguished Senator from Rhode Island, particularly with Families USA, is on to something that really constitutes a revolution in consumer protection. What we have seen on one issue after another—just a few minutes ago the distinguished Senator from Arizona, Mr. MCCAIN, and Senator DODD of Connecticut, and I were able to get an agreement on the Y2K issue with respect to trying to hold down frivolous lawsuits surrounding Y2K. What the Senator from Rhode Island and Families USA have been able to do is essentially say in the health care system: We are going to do everything we possibly can to limit frivolous lawsuits; we are going to help people when they need it most, when the problem first develops.

I want to assure the Senator from Rhode Island and the distinguished Senator from Massachusetts that I am anxious to work with them on this proposal, because I think this is one of the areas where the parties ought to be able to come together. It may sound quaint, but the ombudsman notion is simply good government. It is preventive kind of medicine.

I thank the Senator for the chance to work with him on it. I will not ask him to yield further. But I am very hopeful that in the days ahead both political parties can see the merit in this idea and have it included.

Mr. REED. Before yielding the floor, let me just say that I, along with my colleague from Oregon, must recognize Families USA and Ron Pollack for the inspiration and thoughtful analysis that helped propel this proposal. It is a good one.

Frankly, we could do very well in this Senate this year if we could protect children through better managed care legislation and give all of our citizens a real voice in our health care decisions through an ombudsman program. This will be a very satisfactory and very successful endeavor for all of us in the Senate.

With that, I yield the floor.

The PRESIDING OFFICER (Mr. SMITH of Oregon). The Senator from New Hampshire.

Mr. GREGG. Mr. President, are we in morning business?

The PRESIDING OFFICER. The time for morning business was concluded at 5 p.m.

Mr. GREGG. Mr. President, I ask unanimous consent that I be allowed to speak for 10 minutes as if in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

MEDICARE

Mr. GREGG. Mr. President, I want to comment on the President's proposal relating to Medicare, and specifically relevant to the drug benefit which has been put forward by the President today and by his staff.

I think the American people have to look at this in the context of the history of this administration's efforts in the area of health care. We know that when this administration came into office, Mrs. Clinton was assigned the task of developing a health care proposal. She came up with what has become known as ''Hillary Care,'' which was essentially a nationalization of the health care system. It was intricate bureaucracy that basically was so interwoven and so complex that it was totally impossible to recognize.

It needs to be noted in evaluating the drug component on this recent proposal on Medicare, the proposal of the Clinton administration on general health care issues as it came forward under Mrs. Clinton's plan, known as ''Hillary Care,'' was a dramatic invasion of the health care delivery system in this country by the Federal Government. It was essentially a nationalization of the system with huge complexities and huge intricacies. That was followed by a number of other initiatives which were lesser but equally aggressive in their attempts to move to the Federal level control over functions of health care in this country.

Then on the issue of Medicare, a commission was set up. The commission was to be balanced. In fact, the President had a large number of appointments to it, and the Senate and House had a large number of appointments to it. It was chaired by a Democratic Member of the Senate, Senator BREAUX.

That commission was to resolve this matter. It was to come forward with a proposal to address the long-term solvency of Medicare and, within that, the drug benefit for senior citizens. The commission did great work, yeoman's work. They came up with a proposal. More than a majority, a significant majority, of the commission supported the proposal which had in it a drug component, and the President walked away from the proposal, even though